RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100348 SEPARATION DATE: 20040915

BOARD DATE: 20120301

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SGT/E-5 (11B20 / Infantryman), medically separated for cognitive disorder secondary to traumatic brain injury (TBI) and left facial nerve palsy secondary to head injury. The CI was injured in Apr 2003 in Iraq when his HMMWV rolled over. He sustained a closed head injury with multiple comminuted cranial/facial fractures (left temporal, occipital, parietal, maxilla), a subdural hematoma, subarachnoid hemorrhage*,* retro-orbitral hematoma, bilateral temporal lobe contusions, injury to the basal ganglia, left cranial nerve VII paresis, and left clavicular fracture. He underwent multiple surgeries, including two laparotomies, tracheostomy, vetriculostomy, gastrostomy tube, and multiple chest tubes. Despite post-operative rehabilitation, the CI was unable to return to duty. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued permanent a P3/U2/H3/S2 profile and underwent a Medical Evaluation Board (MEB). Cognitive disorder secondary to TBI and left facial nerve palsy secondary to head injury were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Three other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the cognitive disorder secondary to TBI and left facial nerve palsy secondary to head injury conditions as unfitting, rated 10% each; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI did not appeal, and was medically separated with a 20% combined disability rating.

CI CONTENTION: “Since my discharge I have not been able to hold a steady job. The Army was my life, what I wanted I was halfway to retirement and they would not allow me to reclass or teach as an instructor. The VA has found me to be 100% based on the injuries found by the Walter Reed med board.” He also attached a copy of his VA rating decision; a contention for inclusion in the separation rating of his VA conditions is therefore implied.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Admin Correction IPEB – Dated 20040628** | | | **VA (4 Mos. After Separation) – All Effective 20040817** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Cognitive Disorder Secondary to TBI | 8045-**9403**  *See text* | 10% | Cognitive Disorder Secondary to TBI…\* | 8045-9327\* | 30%\* | 20041211 |
| L Facial Nerve Palsy… | 8207 | 10% | L Cranial Nerve VII Palsy | 8207 | 10% | 20041109 |
| Headaches | Not Unfitting | | TBI w/ HA & Dizziness | 8045-8100 | 10% | 20041109 |
| L Hearing Loss | Not Unfitting | | Hearing Loss, L Ear | 6100 | 0% | 20041109 |
| L Sternoclavicular Dislocation | Not Unfitting | | Degenerative Changes L Shoulder… | 5010 | 10% | 20041109 |
| ↓No Additional MEB/PEB Entries↓ | | | Residuals Fractured Maxilla | 9916-9905 | 10% | 20041109 |
| 0% x 5/Not Service Connected x 0 | | | 20041109 |
| **Combined: 20%** | | | **Combined: 50%\*** | | | |

\*Added tinnitus 6260 at 10% effective 20041113 (combined 60%) on the original VARD dtd 20050311; cognitive disorder 8045-9327 changed to PTSD w/ cognitive disorder NOS, 9411-9327 effective 20040817 maintaining the 30% rating; VA combined ratings of 70% from 20070131 (facial scars at 30%) and 100% (9411-9327) effective 20080428.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred condition has had on his current earning ability. The Board further notes the current Department of Veterans’ Affairs (DVA) rating (100%; with attached VA rating decision) cited by the CI for his service-connected conditions, but must emphasize that its recommendations are premised on severity at the time of separation. The VA ratings which it considers in that regard are those rendered most proximate to separation. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the DVA. The Board uses DVA evidence proximate to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. The Board must also apply the VASRD rules in effect at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Cognitive Disorder Secondary to TBI Condition. This diagnosis and its etiology from OIF-incurred TBI are well supported by the record and acknowledged by the PEB. The CI’s April 2003 head injury was significant, including a depressed preoccipital (parietal) fracture and basilar skull fracture with cerebrospinal fluid otorrhea, subarachnoid hemorrhage, and retro-orbital hematoma. Although the PEB and VA arrived at different codes and ratings, they apparently applied the same rating criteria, VASRD §4.130 general rating formula for mental disorders under 8045-9327 for cognitive disorder secondary to traumatic brain injury to include diffuse subarachnoid hemorrhage and retro-orbital hematoma. There was an apparent typographical error on the PEB’s DA Form 199, where diagnostic code “9403,” specific (simple) phobia, or social phobia, was used in place of “9304,” dementia due to head trauma. There were no reports of phobic symptoms in the record, and 9304 is clearly the most appropriate code in this case (with the 8045 prefix). It is also noted that the VASRD in effect at the time of separation preceded the contemporary rating scheme for TBI or additional interim VA guidance on rating TBI (training and FAST letters); the Board is obligated to apply the older VASRD in effect at the time of separation in its rating recommendation. The 2004 VASRD criteria for brain disease due to trauma, 8045, stipulated:

Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045–8207). Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

The cognitive deficits described in this case, are the main substrate for coding under the PEB’s 8045-9403 (or its intended 8045-9304, or the VA’s 8045-9327) approach where 9327 is “organic mental disorder, other.” The CI had an axis I diagnosis of “cognitive disorder NOS due to traumatic brain injury.” There was an extensive battery of neurocognitive testing performed by an MEB consultant seven months prior to separation. The CI scored in the moderately impaired range on one measure of visual focused attention and psychomotor speed/persistence, and was noted to have slowed information processing and visual scanning with motor response; he scored in the normal range on tests including general intellectual abilities, memory, executive control, language, and visual-spatial functioning. His score on the Beck depression inventory was 21, suggesting moderate mood symptoms. The tests and conclusions are summarized in this excerpt from the psychologist’s report:

Against a background of average general intellectual skills, the current neuropsychological test results indicate significantly improved cognitive functioning with only a few areas of residual difficulty noted. These include some variability in attention, with moderate impairment noted on a measure of speed of processing and focused attention. Some mildly reduced manual speed and dexterity on the left was also noted. The other areas assessed including language, memory, visual-spatial perception, and executive functioning were within normal limits. Emotionally, SGT Garrison shows some depressive symptomotology superimposed on more longstanding antisocial personality characteristics. The attentional/speed of processing impairment noted is likely of sufficient severity to prevent him from adequately performing his military duties. As almost a year has passed since the injury, little further spontaneous progress in this area can be expected.

The psychiatric addendum to the MEB, seven months pre-separation, reported the CI denied any anxiety, depression, memory deficits, or other psychiatric issues. On his MEB history form (the same month); however, the CI noted difficulty sleeping, some depression and excessive worry (about his medical condition and future regarding studying in college), and short term memory loss. The psychiatric MEB examiner reported the CI attempted to start college the month prior, but was called back to Walter Reed to complete his MEB. Mental status exam (MSE) was normal. Global Assessment of Functioning (GAF) was 70, indicating some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, having some meaningful interpersonal relationships. The CI’s only axis I diagnosis was cognitive disorder NOS due to TBI, “resolving, with only mild attentional difficulties.” The examiner assessed military impairment as moderate, and impairment for social and industrial adaptability as mild.

The VA psychiatric exam, two months after separation, reported more significant psychiatric symptoms, including depression (with “good days and bad days”), social isolation, lack of motivation, and insomnia. The CI was employed (setting up large scale events), and lived with his cousin (roommate). MSE was normal except for mood, which was characterized as “good days and bad days.” The examiner specifically noted the CI’s recent and remote memory appeared intact, he had no difficulty with concentration, and he appeared “cognitively intact.” GAF was 68, the same (mild) range as the MEB addendum. The VA assigned a 30% evaluation based on this exam, for the CI’s cognitive disorder secondary to TBI. Although remote from separation, the Board noted that the CI’s psychiatric condition apparently deteriorated, and he was diagnosed with PTSD (38 months after separation), major depression, and alcohol abuse (as well as cognitive disorder), as noted in VA exams 41 and 44 months after separation. GAFs ranged from 63-65 (the same mild range as the two-month exam) at the 41-month exam, to 44 (indicating serious symptoms or serious impairment in social or occupational functioning) at the 44-month exam. The CI was unemployed at the 44-month exam, having left his job as a truck driver (which he worked from 40 to 42-months after separation) due to problems with memory and concentration. The examiner also noted the CI had full social security disability benefits. The VA increased their evaluation for PTSD to 100% based on this exam and the worsened symptoms. This was considered post-separation worsening, not indicative of the CI’s condition at separation.

The Board directed its attention to its rating recommendations based on the evidence described above. The Board first considered whether the CI’s diagnosis was the result of a “highly stressful event,” IAW §4.129 (mental disorders due to traumatic stress). The stressor, in this case was the vehicle accident that caused the CI’s injuries. The CI’s brain injury, however, and subsequent cognitive impairment were clearly related to trauma, and not to stress. The Board adjudged that the provisions of VASRD §4.129 were not appropriate to apply in this case. The Board then directed its attention to determining the most appropriate fit with VASRD §4.130 criteria for its rating recommendation. The CI’s cognitive complaints were documented in objective tests of neuropsychiatric performance; therefore his TBI picture consisted of more than the “purely subjective complaints” with the 8045 restriction of rating at no greater than 10% under 9304. The CI’s subjective complaints of headache, dizziness and sleep disturbance were considered “purely subjective complaints” and coding under §4.130 criteria for the cognitive disorder was predominant.

The Board deliberated on the CI’s §4.130-level rating at the time of separation between the 10% and 30% criteria. The VA exam two months after separation was the most detailed and most proximate exam to separation to estimate the CI’s condition at separation. Although rated by the VA at 30%, there was little documentation of occupational and social impairment, and the GAF and symptom descriptions appeared closest to the mild level. Pre-separation evidence, including the MEB psychiatric addendum, MEB history form, and MEB neuropsychiatric addendum, supported a 10% rating, although taken together and over time, could potentially support a 30% rating. The PEB’s note regarding the CI’s ability to ride a motorcycle and walk in the woods (as stated in the NARSUM), did not run counter to the 30% level of impairment. Nevertheless, given the CI’s history of starting college prior to separation, employment after separation, and normal performance on tests of “intellectual abilities, memory, executive control, language, and visual-spatial functioning,” the Board agreed that the CI’s level of functioning at separation best fit the VASRD §4.130 10% criteria, “occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication.” All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s 10% rating decision for the cognitive disorder secondary to TBI condition, but the Board recommends a change in the VASRD code to 8045-9304 (to correct the coding from the likely typographical error of 8045-9403).

Left Facial Nerve Palsy Secondary to Head Injury Condition. The CI’s facial nerve palsy was a result of the head trauma sustained in the HMMWV rollover described above. For this condition, the PEB and VA arrived at the same rating and coding decisions, 10% under 8207, paralysis of the seventh (facial) cranial nerve. The CI’s facial nerve-related impairments described in the NARSUM, five months prior to separation, included slowness in eating, difficulty drinking out of a straw, left facial droop, drooping of the left eyelid (ptosis; eyelid opening is a cranial nerve III function) and sluggish left eyelid closure with having had a gold implant in his upper eyelid to aid closure; ptosis did not interfere with sight. The CI was using eye lubricants. The examiner stated, “other than his memory and concentration difficulties, this was his most troublesome problem,” and that the CI “had to be careful when walking through the woods or riding his motorcycle since he cannot close the eyelid very quickly.” The CI had not noted any improvement in this condition in recent months. Physical exam revealed left facial droop, left eye ptosis, and paralysis of the left facial muscles except for “trace movement in the left eyebrow region and left side of the mouth.” No left sided sensory deficits were described, although right temporal and periauricular deficits were noted.

Two VA Compensation and Pension (C&P) exams at two and three months after separation documented similar facial nerve impairments, with the history indicating “his left side has gotten better since the initial accident, with improvement of less drooping of the face on the left side too.” The CI’s speech was “dysarthric and faceted by the facial nerve palsy.” There was left sided facial droop and ptosis, and the mouth was slightly deviated to the right. The left eyelid did open under pressure (cranial nerve III function), and the eyelid weight was noted. There was no loss of sensation on the left side (only on the right). The CI no longer required lubricants for the left eye (seventh nerve affects tears/lacrimation).

The Board noted that the facial nerve condition was peripheral (lower motor neuron)rather than due to central damage to the brain (i.e., not due to brain trauma-upper motor neuron) as envisioned under VASRD hyphenated 8045 (due to TBI) coding. The Board deliberated over whether the CI’s documented incomplete facial nerve paralysis could be considered moderate (10%) or severe (20%). The MEB exam was more detailed, but slightly further from the date of separation. The VA exams were after separation, slightly closer to the date of separation; but, slightly less comprehensive. It may also have included after separation improvement of the condition. The MEB exam supported the severe (20%) rating, while the VA exam was closer to the moderate (10%) level. The Board considered the relative loss of innervation of facial muscles, the need for implanted eyelid weight, and the resulting impairment to more closely reflect incomplete severe (20%) paralysis. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board majority recommends a separation rating of 20% for the left facial nerve palsy condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were headaches (VA 10% for TBI with headaches and dizziness), left hearing loss (VA 0%), and left sternoclavicular dislocation (VA 10% for degenerative changes, left shoulder). Hearing loss and dislocation of left clavicle were profiled (H3 and U2). None of these conditions were implicated in the commander’s statement or noted as failing retention standards.

The NARSUM noted the CI’s headaches were relatively frequent (5-6 times per week) and required daily narcotic medications to control, but also noted the CI was “able to function during his headaches,” and did not require any emergency room visits. The two-month after separation VA exam reported similar findings, except that the frequency of headaches had increased to daily, and non-narcotic medications (Advil or Tylenol), along with naps, provided relief. The CI’s subjective complaints of headache (along with dizziness and sleep disturbance) was considered under “purely subjective complaints” above in coding the CI’s cognitive disorder due to TBI.

The CI’s left ear hearing loss was characterized as “severe/profound conductive hearing loss” in pre-separation audiologic evaluation; however, his speech discrimination score was 100% at 75 dB (masked) in the left ear, compared to 96% at 60 dB (normal conversation level) in the right ear. No hearing aids were recommended. At his two-month post-separation VA audiologic evaluation, the CI had a Maryland CNC speech recognition score of 96% in the left ear, compared to 100% in the right. The VA rated his left ear hearing loss at 0% based on this exam. Any potential involvement from the CI’s seventh nerve condition impacting hearing was considered above in rating the unfitting seventh nerve condition.

The CI’s left shoulder condition did not limit his range of motion significantly, but caused pain, especially when lifting weights (over 25 pounds) or trying to reach his mid-back with his left hand. The NARSUM also noted subjective weakness, but on exam, strength was normal (5/5) and range of motion full. Degenerative changes in the left acromiolavicular joint were acknowledged from his physical medicine evaluation three months prior. The VA exams did not reveal significantly different findings, and the VA assigned a 10% evaluation to the CI’s left shoulder condition. The CI’s permanent profile specifically cited the shoulder condition, indicated a U2 designation, and prohibited pushups (other APFT events were allowed) and lifting more than 25 pounds with the left arm.

The Board’s threshold for countering DES fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 “fair and equitable” standard.

All the above conditions were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. All evidence considered, there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for: residuals of fractured maxilla (VA 10%); tinnitus (VA 10%); multiple skull fractures, to include left parietal, occipital, and basilar areas with retained foreign bodies (VA 0%); inability to close left eyelid status post weight implant (VA 0%); ruptured left tympanic membrane status post surgical repair (VA 0%); and multiple scars, tree inch scar behind left ear, 12 inch scar on abdomen, nine inch scar on back, and one inch scar trach area (VA 0% initial; 30% from 31 January 2007). Tinnitus was not documented in the DES file. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The maxillary fracture condition was reviewed by the action officer and considered by the Board. The NARSUM indicated the CI’s only significant complaint related to his facial fracture (other than the facial nerve palsy) was decreased jaw opening. This was evaluated by otolaryngology and found to be 37 mm, which was considered adequate. The CI elected not to have surgery, which was expected to increase his jaw opening to about 45 mm. The only noted functional impairment of the decreased jaw opening was slower eating, which the CI felt may have also been due to the facial nerve palsy. There was no evidence for concluding that the maxillary fracture condition interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were: right index finger laceration with numbness; nystagumus with right gaze; left ankle torn ligaments (2001); left hip puncture laceration (2000) secondary to motorcycle crash; fractured leg and arm (august 1999) in motorcycle accident; history of prolonged cough secondary to pneumonia (resolved); blurred vision and diplopia following head trauma from motor vehicle accident (resolved); tracheostomy, gastrostomy, appendectomy, laparotomies following motor vehicle accident, right ear hearing loss; occasional epigastric pain; acne; and single seizure episode (May 2003). Several additional non-acute conditions or medical complaints were also documented. None of these conditions were occupationally significant during the MEB period, none carried attached profiles, and none was implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to separation rating. No other conditions were service-connected with a compensable rating by the VA within twelve months of separation or contended by the CI. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the cognitive disorder secondary to TBI condition, the Board unanimously recommends no change in the PEB rating of 10%, but a change in VASRD code to 8045-9304 IAW VASRD §4.124a and §4.130. In the matter of the left facial nerve palsy condition, the Board by a vote of 2:1 recommends a service disability rating of 20%, coded 8207 IAW VASRD §4.124a. The single voter for dissent (who recommended no change in the PEB 10% adjudication) did not elect to submit a minority opinion. In the matter of the headaches, left hearing loss, and left sternoclavicular dislocation conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the fractured maxilla condition, or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Left Facial Nerve Palsy Secondary to Head Injury | 8207 | 20% |
| Cognitive Disorder Secondary to TBI | 8045-9304 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110423, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

XXXXXXXXXXX

President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXXX, AR20120010210 (PD201100348)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum.

a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA